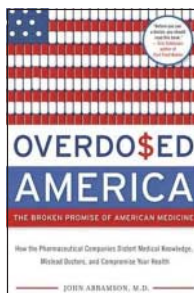


reviews

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Overdo\$ed America: The Broken Promise of American Medicine

John Abramson



HarperCollins,
\$24.95/\$34.95, pp 352
ISBN 0 06 056852 6
www.harpercollins.com/

Rating: ★★

With so much negativity towards medicine these days, many doctors must be contemplating earplugs and wondering why they are bothering. Thanks to Harvard University researcher and family doctor John Abramson, that negativity is about to be turned up a notch. His book is the latest in a series of searing indictments of a medical profession apparently duped by the false promise of technology, and too often compromised by cold hard cash from the companies selling the drugs and devices. Yet this book comes with a refreshing respect for the healing potential of the doctor-patient relationship, and a clear commitment to making the healthcare system more humane. The title speaks of the United States, but the themes are global.

Much of the material about drug companies distorting science will be familiar to many readers, but there is a freshness here that carries great appeal. The author combines his personal journey towards increasing scepticism with a clear analysis of where the American health system is failing. The book's focus is big pharma's unhealthy influence, but it places that subject within a much broader global context: the growing commercialisation of medicine; the limits of the biomedical approach; and the moves to widen the ways in which communities and nations can try to improve human health.

As Britain's House of Commons health select committee investigates industry's influence over the entire health system, as authorities in the United States and elsewhere continue to be convulsed by revelations about the dangers of widely prescribed antidepressants, and as a global campaign to re-invent academic medicine takes shape—part run by the *BMJ*—Abramson's book could not be more timely. What it lacks in

terms of a compelling narrative, it makes up for with powerful and engaging insights.

The personal journey starts with this doctor's bewilderment at discovering the truth about COX 2 (cyclo-oxygenase-2) inhibitors, the overhyped new class of anti-arthritis drugs, and his sense of betrayal at finding out that such distortions are no longer uncommon. The story of celecoxib (Celebrex) and rofecoxib (Vioxx), and the far-too-favourable portrayal of their risks and benefits in both marketing materials and published trials, is told through anecdotes about interactions with real patients.

Particularly fascinating is Abramson's argument that marketing campaigns encouraging unnecessary demand are undermining the trust between a doctor and patient. It is not a new argument, but he has a moving formulation of it. With great discomfort, we hear how this family doctor wrote a prescription for a much advertised pill that he was convinced his patient did not need, in order to maintain a relationship with that patient. In another scene, the author wonders how many people he may have injured in the 1980s, by prescribing a notorious class of anti-arrhythmic drugs, belatedly shown to take life away rather than save it. Importantly no one is singled out for blame in this book, but rather "the enemy is us."

Moving from the personal to the political, the book explores the abundant evidence about the far-reaching pharma influence over medical practice, education, and research: from the friendly drug reps to the rigged trials, from the timid regulators to the bought-off thought leaders. "Doctors who allow their reputations and academic positions to be leveraged by drug companies for commercial purposes provide a crucial link in the chain of corporate influence," Abramson writes. The media also come in for criticism for their mindless "break-through cure" formulas in medical news stories, boosting sales more than enlightening readers or viewers.

As I read this book, and watched the wider global debates about commercial influences on medical science, one question kept demanding an answer. Given what we know now of the distortion of medical knowledge and practice, why aren't more doctors, health professionals, policy makers, and patients clamouring for a form of health care characterised by much greater independence from unhealthy commercial influences?

Abramson provides part of the answer: "Once a doctor starts questioning accepted medical knowledge, he or she immediately



Abramson's themes are global

risks becoming an outsider, a boat-rocker, losing respect and legitimacy earned during those long years of training."

The other part of the answer is that the push for major reform, though disparate, is in fact gathering steam. At the medical coal-face, many academic medical campuses, patient groups, and professional societies are now debating the extent of their entanglement with drug companies. Inside Westminster itself, while acknowledging the enormous value of medicines, a British parliamentary committee is discussing how it might wind back unhealthy drug company influence on the system as a whole. And finally, the long term campaign for clinical trial registries seems to be bearing fruit.

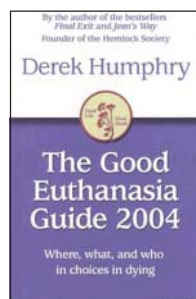
Without risking legitimacy, there are some small, simple, practical steps that concerned doctors can take, and many already have: stop seeing company reps, stop attending company sponsored education, stop accepting gifts, and stop accepting money to speak on companies' behalf. If a recent *BMJ* poll is any indication, there is considerable interest in these and other moves to enhance independence (<http://bmj.bmjournals.com/misc/docdrug.shtml>).

Pursuing such disentanglement is not anti medicines, or anti drug company. On the contrary, it is about trying to achieve better informed decisions about how to use medicines, at the level of the patient and the population. The products drug companies make are essential ingredients to any health system, their excessive marketing and egregious influence-peddling, as Abramson shows, are simply unwelcome.

Ray Moynihan visiting editor, *BMJ*
raymond.moynihan@verizon.net

The Good Euthanasia Guide 2004: Where, What, and Who in Choices in Dying

Derek Humphry



Norris Lane Press, \$12, pp 208
ISBN 0963728083
www.finalexit.org/

Rating: ★★

Dispel any ideas of choice this title conveys: euthanasia cannot be selected like a pub or restaurant. Euthanasia and assisted suicide enjoy varying degrees of legality in the Netherlands, Belgium, the state of Oregon, and Switzerland, but only the last allows foreigners to access euthanasia services. There, only one group, the Zurich based Dignitas, is prepared to help. This has courted a controversy. Suicide may be legal, but helping with it generally isn't.

Humphry, originally a journalist, has an eye for a catchy title, but this subject is hot

enough by itself. The campaigner for the right of patients to die has, over three decades, enjoyed notoriety, especially since the 1991 publication of his controversial but enduringly popular "how to" book on suicide, *Final Exit*.

That book, whose later editions include matter of fact descriptions of how to commit suicide by a method involving the inhalation of helium, has, the author claims, enjoyed sales exceeding a million. The most shocking fact in *Final Exit* was that it appeared to meet a need. That need is shown again by the *Good Euthanasia Guide*. Few doctors can ignore the striking picture Humphry paints of right to die pressure groups across the world constantly challenging governments, laws, courts, and the medical profession.

One moment Luxembourg is voting down, by one vote, a law permitting euthanasia; the next New Zealand is voting by just 60 to 57 not to implement a law similar to that in the Netherlands, and writer Lesley Martin is beginning a 15 month prison sentence for helping her mother die. In Canada grandmother Evelyn Martens is set to stand trial for helping two dying people to commit suicide. The Council of Europe, meanwhile, has agreed a draft resolution saying that nobody has the right to impose on terminally ill people the obligation to live out their life in unbearable suffering against their wishes.

Like many people on both sides of the debate Humphry writes with evangelical fervour. His conviction is partly drawn from personal experience. He helped both his first wife and his father in law commit suicide. I don't doubt his compassion when he writes: "I wish I didn't have to have helped these two people die." But whether these experiences have clouded his judgment or given value to his opinion is debatable.

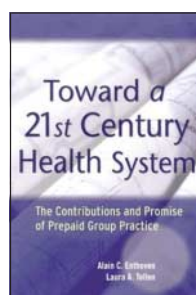
What is not questionable is his knowledge of the right to die movement, having co-launched the Hemlock Society in 1980. He writes authoritatively on the social history of the movement in the United States, the split with Dr Jack Kevorkian, and the political struggles in Oregon and Maine. The book even has a welcome touch of humour in his cheeky assertion that it was the Monica Lewinsky affair that prevented Congress from overriding the Oregon law.

Listing nearly 50 right to die groups in almost 25 countries suggests that Humphry may be right in his generalisation that it is "an idea whose time has come." Less fair is his claim that medical associations have their "heads in the sand." If this means not coming to the same conclusions as him, then maybe, but if it means ignoring the issue a glance at the pages of the *BMJ* refutes this.

Tony Sheldon freelance journalist, Utrecht, Netherlands
Tonysheldon5@cs.com

Toward a 21st Century Health System: The Contributions and Promise of Prepaid Group Practice

Eds Alain C Enthoven, Laura A Tollen



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ISBN 0 7879 7309 2
Also available as an ebook
www.josseybass.com

Rating: ★★

Managed care, which stemmed the annual rise in healthcare costs in the United States from a high of around 18% to something closer to 4%, may be losing steam, as those increases are now back into double digits. An alternative, according to the more than 20 contributors to this book, is prepaid group practice (PGP). A PGP is "an integrated entity that includes both a healthcare delivery system (doctors, other clinicians, laboratories, clinics, and hospitals) and an insurance function (financing arrangements, benefit plans, marketing, and customer service systems) 'under one roof.'" Its main components are professionals from various specialties, a voluntarily enrolled

population, comprehensive service, prepayment by people enrolling, and accountability for the quality and cost of care.

William Roper, one of the authors and dean of the School of Public Health at the University of North Carolina at Chapel Hill, notes that the potential of PGPs lies in four areas: culture (the fact that clinicians seeking employment in such groups tend to be less conventional than other doctors, which makes it easier to foster and maintain a culture that focuses on quality); infrastructure (investment in clinical information systems, patient education and support systems); compensation and reward systems, with incentives for cost restraint and quality; and close collaborative relationships with such partners as hospitals and health plans.

The centrepiece, though, seems to be the fact that because they know their patient population and its characteristics PGPs can tailor treatment to meet individual patients' needs and use cost effective interventions.

The authors say that the biggest obstacle to streamlining the US healthcare system, which the book describes as a "the poster child for underachievement," isn't a lack of money, technology, information, or even people, but rather the absence of an organising principle that can link money, people, technology, and ideas into a system that delivers more cost effective care. This is a desirable objective in a country that now spends about \$6500 (£3600; €5340) per person on health care a year—a whopping

total of \$1.5 trillion—while still leaving some 44 million people without health insurance.

But reaching this goal will take serious commitment and effort. Almost half of all private doctors in the United States still work in practices of one or two doctors, and more than 80% are in practices of nine or fewer. Moreover, despite the advocacy for PGPs suggested in the subtitle, the book is remarkably free of outright proselytising. It notes, for instance, that the US health system is not yet at the threshold for fundamental change. "And until it is... the PGP is unlikely to grow much beyond its current state."

In fact, Donald Berwick, president of the Institute for Health Care Improvement, lists several barriers to improvement of PGPs. These include perceived erosion of professional autonomy, with some doctors fearing evidence based care protocols as restrictive; old habits that may preclude accepting full involvement of patients in their care; and resistance to information technology innovations.

So where do PGPs go from here? The authors note that "in the absence of a clear crystal ball, it seems reasonable to suggest that PGPs will be challenged to repeat their past successes." They add: "First they will need to find a new motivation that replaces their need to establish legitimacy."

David Woods chief executive officer, Healthcare Media International, Philadelphia
dwoods@healthpublishing.com



Journalists on Prozac

Did major media outlets fail to ask the right questions about depression study?

Recent headlines announcing the results of a US study of clinically depressed adolescents were unequivocal: "Talk and pills best for depression in kids" (CNN.com); "Prescribed drugs with therapy aid teen depression" (*Wall Street Journal*); "Combination aids depressed youths" (*New York Times*); and "Prozac plus talk is best for teen depression" (*Washington Post*).

The headlines were matched by the exuberant claim of the study researchers who said that 71% of teenagers treated with a combination of fluoxetine (Prozac) and cognitive behaviour therapy improved—compared with only 35% of teens treated with placebo alone. That claim, published last month (*JAMA* 2004;292:807-20), was based on data from the Treatment for Adolescents with Depression Study (TADS), a nationwide, 13-site study of 439 depressed adolescents.

But several points that might concern both laypeople and scientists went unreported by the *New York Times*, *Washington Post*, *Wall Street Journal*, *US News & World Report*, the Associated Press, National Public Radio's (NPR) *Science Friday*, and CNN.

Not one of these media giants reported that two of the study's four treatment arms were unblinded—and that it was in one of these unblinded arms that the purported benefit of fluoxetine was described. Lead author Dr John March of Duke University, North Carolina, declared fluoxetine plus talk therapy "the big winner" in an interview with wire service *HealthDay* reporter Serena Gordon—a phrase he would repeat a few days later to NPR's Ira Flatow. Yet the NPR interview did not mention that in the winning arm teens knew that they were receiving fluoxetine and not placebo, nor did that information appear in Gordon's article. Nor did news reports mention that in the two blinded arms, fluoxetine failed to perform better than placebo on the key Children's Depression Rating Scale. That news could not be found in reports by NPR, *HealthDay*, the *New York Times*, *Wall Street Journal*, or *Washington Post*. Nor were there interviews with or comments from methodologists, who might have assessed the robustness of data derived from such an unblinded treatment arm.

Dr March told the *BMJ* that "none [of the journalists] had read the methods paper." He added, "Most were interested in the main take home message of the TADS,

not in methodological sub-issues, none of which seriously call into question the main results." News releases by *JAMA* and the National Institute of Mental Health (NIMH)—intended for the media—also did not mention these points, although the news release by Duke University acknowledged the unblinded nature of two arms of the trial.

There is an apparent consensus among physicians about the value of fluoxetine. Both US and British medical authorities have concluded that fluoxetine is safe and effective for depression in children. Even such notable critics as Dr Andrew Mosholder (whose report finding increased suicidal behaviour among adolescents treated with antidepressants was suppressed by the US Food and Drug Administration) concluded, in his February report, that fluoxetine was safe and effective for children (*BMJ* 2004;329:307).

Journalists should dig deeper when researchers claim a treatment is effective

But some commentators argue that it is precisely when scientific opinion appears uniform that journalists need to be especially careful to scrutinise their sources and ask critical questions.

After the US Senate Select Committee on Intelligence concluded that "group think" led the Central Intelligence Agency to inflate their intelligence assessments about weapons of mass destruction in Iraq, the *New York Times* and *Washington Post* admitted failing to identify the interests of their sources and failing to examine carefully their claims.

Journalists can play a critical role in preventing "prevailing opinion" from becoming "group think" by adhering to basic principles, such as those put forth by the US based Association of Health Care Journalists. The association encourages writers to "investigate and report possible links between sources of information (studies or experts) and those (such as manufacturers) who promote a new idea or therapy" and to "present diverse viewpoints in context."

Dr Peter R Mansfield, director of Healthy Skepticism (www.healthyskepticism.org) and research fellow at the University of Adelaide, Australia, said journalists should ask questions about study methodology, look carefully for the completeness of data, and challenge how the data are spun. "They need to question how benefits and risks are reported and how their impact can be exaggerated or minimised by researchers through various statistical manipulations. And they need to know how to find credible experts who can critically assess a study's validity."

Journalists should dig deeper when researchers claim a treatment is effective, said Dr Mansfield. "Effective is not a yes or

no dichotomy. They need to ask, 'How effective?' and 'Do the risks outweigh the effectiveness?' Six of the seven suicide attempts in TADS were made by adolescents treated with fluoxetine. Only one child not on fluoxetine attempted suicide. This wasn't statistically significant, but it may be clinically significant when six times as many children on the drug attempt suicide as those on placebo. The data do not support the claim that the benefits outweighed the risks because this study was not powered to determine the risk of suicide."

The TADS researchers failed to report negative data at the same time that they reported positive data. Using a "dichotomised" scoring system on the Clinical Global Improvement (CGI) scale, TADS researchers reported only scores of 1 (very much improved) or 2 (very improved). Negative scores were not reported.

Asked how readers could be assured that fluoxetine didn't just "squeeze the middle"—causing some patients to improve while others worsened—Dr March told the *BMJ* that that wasn't the case. However, when he was asked to supply the *BMJ* with the complete CGI results, including negative scores, he declined, saying "That will be part of a secondary analysis."

Dr Richard Glass, deputy editor of *JAMA*, wrote an accompanying editorial in which he concluded that the TADS data showed that "treatment of carefully evaluated adolescents with moderate to severe major depression can be effective . . ." but that the positive findings "must be qualified" by the "open treatment with fluoxetine." Dr Glass declined to respond to an inquiry by the *BMJ* about whether the *JAMA* editors were given the results of the unreported negative outcomes on the CGI scale. When asked why *JAMA* did not publish the negative CGI scores, he said it wasn't a fair question because it "implies that no negative data were reported." *JAMA* reported negative outcomes on other scales.

Many news reports also did not describe the financial relationships of the study authors with interested parties—or even frankly misstated them. Most news accounts described the study as "publicly funded." *US News & World Report's* Nancy Shute wrote that the study was "significant because it is one of the very few studies of antidepressants that were not financed by a drug manufacturer; instead, backing came from the National Institute of Mental Health."

What Ms Shute and many others did not mention was that the lead author, Dr John March, and five of his co-authors had received funding from Eli Lilly, manufacturer of the study drug, even though these disclosures were made in the *JAMA* article.

Jeanne Lenzer medical investigative journalist, Kingston, New York state, USA
jeanne.lenzer@verizon.net

PERSONAL VIEW

What if the government refuses to ban smoking in public places?

I came across a new TLA (that's "three letter acronym") the other day: KDM. It stands for key decision maker. It was in a great big document that was in my post on how to go about persuading the great and the good to do something to reduce people's exposure to secondhand smoke in public places.

According to this framework for action a large number of public health professionals should devote a great deal of energy to winning the hearts and minds of city councillors, business leaders, trade unions, company bosses, and community leaders to act to limit or ban smoking in public places and in places of work. These people and organisations are the KDMs that we should be influencing.

That's all very well—but the thought occurred to me that there's one KDM that matters more than any other, so much so that if we have this one KDM on board then all the others don't matter at all. And if this one KDM refuses to do the right thing then all the others might as well not bother. I refer, of course, to the government. The government also has the perfect opportunity now, in the public health white paper that is expected to be published by the end of the year, to take what may well be the most important key decision for achieving better public health for the people of this country.

All the medical and public health authorities have called for a ban. The chief medical officer, the government's own top adviser, has set out the case for a ban. Survey after survey has shown that the public and even businesses would support a ban; and other cities and countries around the world have shown that a smoking ban can be easily introduced.

In Ireland the benefits of a ban are already visible: cigarettes sales are down 7.5% according to Gallaher, a company with a 50% share of the Irish market. In New York business in restaurants and hotels and employment have all risen after the smoking ban. Norway has now followed suit, having banned smoking in public places in June.

It seems therefore to be inevitable that the white paper will propose similar action. Surely a government that took us into an unpopular war because it believed that was the right thing to do to protect us from a dire (if unproved) threat would have the courage to ban smoking in public places? Especially given that it would be a measure with popular support and backing from experts and would deal effectively with a present and real threat to our health?

However, rumour has it that the decision on whether or not to announce



In Ireland smokers are now left out in the cold

official government support for a ban on smoking in public places is being left to the very last minute before the white paper is finalised. One news report suggests that Tony Blair favours giving powers to local authorities to introduce any bans. Such a Pontius Pilate approach would hardly do.

What if the ministers decide that a smoking ban would smack too much of the nanny state and leave it out of the white paper? How should the public health community and the health service respond?

I suggest that if the government misses the present opportunity then all of us in the health service should jointly write to ministers to say that we will

- withdraw from all further activity to control tobacco
- disown all targets on reducing the prevalence of smoking and refuse to carry out or fund surveys of smoking prevalence, and
- refuse to supply data on smoking cessation services.

After all, in another era and in another context, when John Snow had identified the source of the cholera outbreak in Broad Street in London's Soho in 1854, the parish guardians agreed for the handle to be removed from the offending water pump. In the context of smoking, only the government is big enough to be able to do something similar. If ministers don't act to do the single most effective thing, why should we in the NHS be complicit by taking part in ineffective activity that allows our leaders to pretend that they are dealing with the problem? Indeed, by scurrying around pretending to influence KDMs that don't matter and providing an excuse for government inaction, we would be doing public health a disservice.

Jammi N Rao *director of public health, North Birmingham Primary Care Trust*
jammi.rao@northbirminghampct.nhs.uk

JNR supports a ban on smoking in public places.

SOUNDINGS

Appeal of the week?

Ever submitted a paper to the *BMJ*? Ever had a reply saying your paper lacked originality, methodological rigour, or credibility on the Clapham omnibus? Believe it or not, the *BMJ*'s rejection letters are more comprehensive, fair, and sensitive than the ones from *JAMA* or the *Lancet*, and its reasons for trashing your work are more likely to be evidence based—at least if a content analysis of my own collection is anything to go by. I'm told that the *British Journal of Phenomenology* invites an account of how you felt when you opened the letter, and the *Journal of Direct Action* provides the editor's home address, car registration number, and route to work.

Look at it from the perspective of the overworked editorial staff. Nine-tenths of what they see is crap. The lads and lasses do a brilliant job of sifting out 98% of the tosh and pulling perhaps 75% of the competent science out of the same haystack. Ninety-four per cent of papers are thus appropriately classified: not bad as a screening test.

Except that these figures (representing the prevalence of tosh and the sensitivity, specificity, and accuracy respectively of the editorial process) mean that the chance that your paper is tosh despite being accepted (that's unity minus the positive predictive value) is 10.8%, and the chance that your paper is great science despite being rejected (unity minus the negative predictive value) is 5.3%. That's two and one papers per week respectively, give or take the confidence intervals. The two pieces of published tosh are immediately available for rapid responses on the *BMJ* website, from which the most incisive contributions will be printed alongside bleatings from the authors and, not infrequently, an admission from the editor that there was a whoopsie somewhere in the process. But the gem that got bounced will remain censored from the public domain until it appears 15 months later in the *Journal of Rejected Papers That Nobody Reads*.

So here's my idea. If selected by an independent appeals editor, your rebuffed manuscript would be placed on a corner of the *BMJ* website, along with the rejection letter, the referees' comments, and your appeal letter, plus a disclaimer saying that this paper has a 94.7% chance of seriously misleading the reader and is not endorsed.

What difference would that make? Let's evaluate the system and find out.

Trisha Greenhalgh *professor of primary health care, University College London*